DOCUMENT RESUME

ED 151 881 CS 502 020

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TITLE Rhetorical Criticism of Psychotherapeutic Discourse.
PUB DATE Nov 77
NOTE 35p.; Paper presented at the Annual Meeting of the Western Speech Communication Association (Phoenix, Arizona, November 1977); See related document CS502030

EDRS PRICE MF-$0.83 HC-$2.06 Plus Postage.
DESCRIPTORS Attitudes; *Behavioral Science Research; Behavior Change; *Counseling Effectiveness; Persuasive Discourse; *Psychotherapy; Rhetoric; *Rhetorical Criticism; Speech Communication; *Therapeutic Environment

ABSTRACT

Rhetorical activity is fundamental to the process of psychotherapy. This paper discusses a study of the consistent use of rhetorical strategies in distinctly different forms of psychotherapy as an initial step in analyzing the effectiveness or failure of therapeutic situations. The data for this two-part study consisted of eleven hours of tape-recorded discourse between three therapists and their clients. For the first analysis, Arnold's nine rhetorical operations were used to examine the dialogue; the paper describes each of these rhetorical operations in detail. In the second analysis, six independent critics tested the reliability of the findings according to four variables: the extent of "ethos" appeals, the extent of logical appeals, the extent of tension release mechanisms, and the extent of stylistic devices. Each of the variables is discussed, and specific segments of therapeutic dialogue are presented to demonstrate how each concept functions as a rhetorical resource. The paper concludes that future research on psychotherapy as a rhetorical process may assist therapists in maximizing the occurrence and maintenance of therapeutic improvement. (HAI)

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RHETORICAL CRITICISM OF PSYCHOTHERAPEUTIC DISCOURSE

by

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Western Speech Communication Association Conference

Phoenix, Arizona

November, 1977

CS502020

Introduction

Psychotherapeutic literature is a quagmire of conflicting procedures and theory (Frank, 1973, p. 201; Corsini, 1973, p. vii). For decades, advocates of varied forms of psychotherapy have argued the effectiveness of their particular method. Despite this effort, no one mode has been demonstrated to be clearly superior at successfully "curing" clients.[1] That all are able to flourish simultaneously despite wide differences in approach suggests that each has something which clients find acceptable and helpful. On the other hand, despite prolonged polemics and proselytizing, no one mode of therapy has demonstrated its superiority. This suggests that there are characteristics common to all types of therapy which probably contribute as much to their effectiveness as the features that differentiate them. (Frank, 1973, p. 23). If these common characteristics are rhetorical processes, it may be possible to uncover some major components of therapist potency which until now have remained elusive.

The therapy process is dynamic and much of what happens is shaped by the interactions between client and therapist (Lennard and Bernstein, 1960). Through analysis of these interactions, this paper presents the therapeutic situation as a rhetorical event with the psychotherapist taking the burden of change-agent. If change-inducing talk is somewhere important in therapy transactions, it becomes critical to find out where it occurs, how, and what its characteristics are and ought to be. This paper will demonstrate a methodology developed for analyzing the discourse between therapists and their clients in an attempt to discover hypothetically predictable, rhetorical strategies and probable consequences.

[1]Phobias are the exception to this statement, responding more promptly to behavioral techniques. However, phobias represent only 3 percent of the people seeking psychotherapy (Frank, 1973, p. 313).

Rhetorical activity, then, is viewed as fundamental to the process of therapy. Clients enter therapy because they are distressed about some aspect of their behavior, thoughts, feelings. The therapist as helper is expected to lead the client to change. In order to facilitate this change, the therapist must influence the client to behave, think, feel differently. Regardless of therapeutic mode, therapists sometimes succeed in this influencing and sometimes they fail. There are times when clients accept the therapist's directives, suggestions, assignments, language, reframing of events, analysis of past history. But there are times when they do not. It is this critical element of the therapeutic chain that the methodology presented in this paper seeks to explain. It is not the purpose of this paper, then, to explain why one particular mode of therapy is superior to another. Instead the paper offers an analysis of the rhetorical resources available or absent in a given segment of therapist discourse. By so doing an attempt is made to clarify why a particular therapist at a given point in therapy is successful or unsuccessful in influencing a particular client.

Data Analysis I: Development of the Methodology

The critical question now becomes: What is the most fruitful approach to studying the rhetorical characteristics of therapist-client transactions? Since the purpose of this investigation was to discover whether rhetorical activity transcends particular approaches to therapy, an attempt was made to explore a variety of (a) forms of therapy and (b) types of problem presented by clients. To indicate how many different conceptual positions are represented in the study, each participating therapist was asked to respond to the following question:

> Which five psychotherapeutic authorities have provided the greatest influence on your therapeutic approach? Please rank order your responses.

Following are the responses received:

Therapist I:
Albert Bandura
B.F. Skinner
Gerald C. Davison
Albert Ellis
Marvin R. Goldfried

Therapist II:
Fritz Perls
Barry Stevens
John Enright
Jim Simkin
Carl Rogers

Therapist III:
C.R. Rogers
H.S. Sullivan
S. Freud
C. Ferster
J. Wolpe

If the range of responses had been narrow, any common rhetorical tendencies in therapeutic discourse would have had to be considered bound to specific theories or techniques. However, the diversity of responses received from the three therapists suggests that they do, indeed, differ in theoretical and philosophical perspectives. Therefore, if rhetorical strategies are found to occur consistently among the therapists analyzed, we may be confident that these tendencies are not specifically bound to certain theories and procedures.

The data in this study consist of dialogue: 11 hours of tape-recorded discourse between three therapist-client dyads. Each of these therapist-client pairs was taped during the first three sessions of therapy, and each session lasted approximately 75 minutes. The discourse was initially analyzed by applying Arnold's nine major rhetorical operations. This procedure for rhetorical criticism was chosen because of its utility in a similar study examining dialogue between intimate partners. (Glaser and Glaser, 1976.) Each of the nine analytical procedures will be described briefly below. More detail will

be given later in the paper when the second stage of data analysis is discussed.

1. Analyzing client discourse to discover prominent therapeutic exigences.

In attempting to discover what might constitute appropriate therapeutic discourse, an attempt was first made to analyze the client-as-audience toward whom that discourse would be directed. As Arnold suggests, this would constitute a step toward determining the rhetoric which that person's perceptual world would find fitting. An attempt was made to examine each client's verbal patterns to discover their imagistic essence or underlying principles. The approaches to image analysis offered by Burke, Kassaway, Cutler, and Bormann yielded the following series of questions that were used to identify and analyze each client's images and to conceptualize the perceptual world the images reveal to the therapist. (Burke, 1969, p. 86; Kassaway, 1967, p. 35; Cutler, 1970, pp. 7-8; Bormann, 1972, pp. 401-402).

> How do this client's images cluster? What meaningful patterns may be found that allude to a perception of reality? What appear to be the dominant or strongest and most frequently occurring image clusters?
>
> Do this client's image patterns reveal the presence of any particular ideas of concepts? How are ideas related and opposed? Does a theme appear? What is its organizational center? Do image clusters suggest the client has a hierarchy of values? What principles guide that hierarchy, organize the suggested perceptual world? Which acts are sanctioned and praised? Which are censored?
>
> Do the image clusters of this client reveal an ideology or world view? What is seen as the historical explanation for problems? How is the future viewed? Do the same people keep appearing as villains? Who are the heroes? For what are the heroes praised and the villains castigated? What emotions dominate: hate? pity? love? indignation? resignation? Do image clusters reveal perceptual changes in the client?

From analysis of clients' image patterns, an attempt was made to discover and describe prominent therapeutic exigences: what was possible, allowable, invited by clients in the communication with their therapists. (Arnold, 1974, p. 30). Once therapeutic exigences had been identified, the rhetorical analysis

proceded by raising Arnold's remaining eight questions which were developed initially for the examination and analysis of explicit and implicit meanings in extended public discourse. These questions constitute an attempt to discover the "suggestive potentialities" of what is said. They help a critic to "uncover what discourse does or does not have the power to do" (Arnold, 1974, p. 70). Each of these eight questions is described below, rephrased for this study to fit client-therapist transactions.

1. What are the simplest interpretations the client could put on the therapist's words? Are these interpretations likely to satisfy the prominent therapeutic exigences (Arnold, 1974, p. 71)?

Arnold contends that speech critics "ought to look for the obvious, not the subtly possible" (Arnold, 1974, p. 71). By searching for "simplest interpretations" in analyzing therapeutic discourse, an attempt was being made to discover the message most likely to be perceived by a client in a given unit of a therapist's discourse. "Simplest interpretation" refers to repetitions of a central idea, couched in either the same or different words. A given meaning is likely to become prominent if it is emphasized in a variety of ways. A therapist, for example, might point to specific instances in the client's history, in the client's current behavior, in the therapeutic literature, or in the therapist's own life. If all emphasize one central residual message, an obvious or "simple" message is apt to be conveyed. If, in addition, the therapist states a central theme directly, we may be even more confident that labeling it as a "simplest interpretation" will identify the residual meaning the client is likely to notice.

2. What is likely to be perceived as explicit claim making by the client? Was sufficient "argument" provided given what is known about this particular client and the demands of this therapeutic situation (Arnold, 1974, pp. 62-63)?

This question proposes inspection of what Aristotle called logos, the content of speech. Toulmin offers a perspective which clarifies how we may estimate the potential strength of a given argument:

> A man who makes an assertion puts forward a claim--a claim on our attention and to our belief . . . its merits depend on the merits of the argument which could be produced in its support . . . . We can, that is, demand an argument; and a claim need be conceded only if the argument which can be produced in its support proves to be up to standard (Toulmin, 1958, pp. 11-12).

The persuasiveness of reasoned argument is confirmed by studies conducted by Brehm and Lipsher (1959). They examined the effects of providing supporting reasons in general attempts to persuade and discovered that communication accompanied by supporting arguments was more likely to result in opinion change than communication without support. But what, exactly, does it mean to "support an argument?" Most simply, it shall refer to the provision of evidence which makes claims appear more reasonable. In analyzing therapist discourse the follwoing were considered to be evidence of support: examples, statistics, citations from authorities. In answering the question about sufficient argument, then, statements most likely to be perceived as explicit claims, as attempts at direct influence, were first isolated, and an analysis was conducted of the arguments provided by the therapist to determine the extent of supporting evidence.

3. What solutions are offered by the therapist for the client's problems and anxieties? Does the therapist provide or lead the client to discover ways of alleviating, managing, tensions and anxieties (Arnold, 1974, p. 76)?

This question is not intended to suggest that it is incumbent upon a therapist to provide solutions to every problem a client generates. It does mean, however, that-when a problem is vivified--either by the client or therapist--ways of alleviating it need to be located either directly or indirectly.

Since tension reduction in therapeutic situations is often subtle, the following are the guidelines used in assessing whether or not solutions were offered for clients' tensions and anxieties. If a therapist performed any of the following acts, it was contended that he or she had provided or had led the client to discover ways of alleviating, managing tensions and anxieties.

1. The therapist offers the client an explicit and direct solution.

2. The therapist assures the client that although the problem does exist, the client is already making noticeable improvement.

3. The therapist minimizes the severity of a problem by suggesting that many people, perhaps including the therapist, have such a problem which can be worked on and solved.

4. The therapist reconceptualizes or reframes the problem to enable the client to view it from a different perspective.

5. The therapist leads the client to discover his or her own solutions to the problem.

4. Are the items essential to the therapist's purpose given special claim on the client's attention by their context, specifically through the use of juxtaposition, analogy, suggested continuity, and figure-ground discriminations (Arnold, 1974, pp. 79-84)?

"Juxtaposition of ideas" refers to statements which occur next to or near one another, for example, an uninterrupted series of statements relating to a given idea. "Analogy" refers to an assertion of similarity between two things, particularly if the similarities introduced by the therapist appear to be obvious and noticeable. Therapists may "suggest continuity of thought" by providing key words and phrases which function to connect a given message, for example repetitions, restatements, connective words such as "moreover,"

"from this information we can see," "next in order," "consequently." "Figure-ground discriminations" refers to special verbal signals which can tell a listener whether an idea is important or tangential to the main theme discoursed upon. The most obvious of these signals is the amount of time spent on an idea. In addition, abrupt signals may gain a listener's attention by suggesting: "What follows is important." Some such verbal aids are: "When you get right down to it," "What's really important," "In spite of that fact."

5. Are the therapist's explicit and implicit claims likely to be viewed as compatible by the client (Arnold, 1974, p. 85)?

The critic's concern here is whether listeners are likely to perceive internal conflict in what is heard, and if so, whether this perception might destroy the overall effectiveness of the discourse. The critical question, then, is whether a therapist's claims in a specific therapeutic situation are likely to be seen as internally consistent and coherent or as self-contradictory.

6. Are the kinds of responses encouraged by the therapist (factual, optative, adjudicative, predictive of desirability) likely to lead to a resolution of exigences that exist in the therapeutic situation (Arnold, 1974, pp. 89-95)?

Factual responses may be encouraged in two main ways. The therapist may ask directly for clarification of the client's remarks, attempting to be certain that facts in question are being understood. Or, a therapist may offer a perception check, condensing all he or she has heard, feeding it back to the client, and asking for agreement or disagreement on this perception of the "facts." Optative responses are invited in those situations where thera-

pists encourage the client to respond by consulting personal standards, values, and tastes. Adjudicative responses evaluate how closely facts conform to formally agreed upon codes. The rules for judgment are impersonal and originate outside the client who need not like the standards to apply them. Responses which are predictive of desirability are invited when therapists ask their clients to weigh the expediency or the harmfulness of a proposed course of action and then to base behavior on these predictions.

7. What does the therapist say to heighten ethos--to increase the likelihood of being perceived as credible by the client (Arnold, 1974, p. 97)?

The findings from a series of investigations concerning therapy as an influence process help us to delineate three components of therapists' ethos: perceived expertness, trustworthiness, and attractiveness. Strong defines expertness as the "perception of a communicator as a source of valid assertions" (Strong, 1968, p. 216). He contends that this perception is influenced by "(a) objective evidence of specialized training such as diplomas, certificates, and titles, (b) behavioral evidence of expertness such as rational and knowledgeable arguments and confidence in presentation, and (c) reputation as an "expert" (Strong, 1968, p. 216). Strong and Matross argue that therapists can increase their perceived expertness by certain behaviors, such as referring to specific areas of expertise. For example, they suggest that a therapist can begin an attempt at influence with, "I have dealt with this problem many times and in my therapy experience it means . . ." (Strong and Matross, 1971, p. 19). Torrey suggests that the naming process is another means by which therapists are able to offer behavioral evidence of their expertness.

> The very act of naming [what is wrong with the client] has a therapeutic effect. The patient's anxiety is decreased by the knowledge that a respected and trusted therapist understands what's wrong (Torrey, 1973, p. 16).

Schmidt and Strong, after studying perceived expertness in therapists, report the following behaviors as indicative of expertise.

> The expert . . . treats [the client] as an equal . . . asks direct and to-the-point questions . . . moves quickly to the root of the problem . . . points out contradictions and suggests possible solutions (Schmidt and Strong, 1970, p. 116).

A second component of therapist ethos appears to be perceived trustworthiness which, Strong concludes, affects the extent to which the therapist is able to influence opinion change in the client (Strong, 1968, p. 219). Frank contends that certain attitudes of therapists must be communicated to the client if trust is to be established. These include ". . . a steady, deep interest, an optimistic outlook, and a dedication to the patient's welfare" in addition to the assurance of confidentiality, which tells the client there are no selfish or devious motives involved (Strong, 1968, p. 222).

Based on the research of Strong and his associates, the third component of therapist ethos appears to be perceived attractiveness. "A communicator's attractiveness is based on his perceived similarity to, compatibility with, and liking for the influence recipient" (Strong, 1968, p. 216). Perceived similarity is often associated with interpersonal attraction (Berscheid and Walster, 1969; Berne, 1961; Schmidt and Strong, 1971), and interpersonal attraction increases the acceptance of influence (Brock, 1965; Strong and Dixon, 1972).

> A therapist develops . . . power by bringing to the client's attention similarities in values, opinions, and experiences. This requires that the therapist reveal himself to the client (Strong and Matross, 1971, p. 11).

Strong and Matross contend that if therapist and client discover strong similarities in world views, the client is more likely to "adopt therapist interpretations, attitudes, and reactions . . ." (Strong and Matross, 1971, p. 10). Strong argues that when counselors communicate their understanding of a client--even if it is derived from theoretical knowledge--such understanding is likely to enhance the client's perception of similarity and compatibility with that therapist (Strong, 1968, p. 222).

8. Does the style of the therapist's talk intensify its content, specifically through the use of balance, antithesis, metaphor, sensory images, intellectual images (Arnold, 1974, pp. 168-69)?

Balances refer to verbal patterns which put ideas in pairs, in a series, or in other parallel constructions. According to Arnold, these balanced groupings have the capacity to make what is said seem "sweepingly true," "impressive," "important," and can, in addition, establish hierarchies and inject interest (Arnold, 1974, pp. 168-69, 173).

Antitheses, although usually balanced in some way, involve ideas that are asserted to be "markedly different," or "opposed to one another" (Arnold, 1974, pp. 182-83). By emphasizing differences and by suggesting conflict, antithetical constructions argue that the contrast or conflict linguistically suggested is true in fact (Arnold, 1974, pp. 173, 183).

Metaphors are "figures of speech in which a term or phrase is applied to something to which it is not literally applicable, in order to suggest a resemblance" (Arnold, 1974, p. 183). Arnold draws on the lore of ancient and modern rhetorical theory to contend that unless metaphors are confusing, distasteful, or hackneyed, they are likely to make communication appear "interesting" and "colorful." Metaphors have the additional capacity to "suggest 'inherent' relationships," and thereby to "'argue' in favor of the interrela-

tionships they assert" (Arnold, 1974, p. 168). For the last of these assertions there is considerable modern, theoretical argument and some empirical evidence (Bowers and Osborn, 1966, pp. 147-155).

Sensory images are defined here as "all words and phrases that seem likely to make a listener think of anything feelable, hearable, tasteable, smellable, or visable" (Arnold, 1974, p. 183). Sensory images presumably encourage listeners to "experience vicariously;" to the extent that this occurs, listeners are more likely to become "experientially, hence feelingly, involved in what is said" (Arnold, 1974, p. 183).

Data Analysis II: Reliability of Findings

Although the results of applying the preceeding operations were carefully argued and appeared reasonable to the author, the question still remained: Would other researchers make the same judgments? To begin answering this question, the author conducted a graduate seminar in "Therapeutic Rhetoric" in which five graduate students were taught how to apply some basic principles of rhetorical criticism to the therapeutic situation. After spending 10 weeks rhetorically analyzing tapes of diverse therapy sessions, each student was given the dialogue initially analyzed by the author. The students analyzed this therapeutic discourse independently, performing seven of the nine rhetorical operations described above. The questions concerning contextual aids and compatible claims were omitted during the course of the term as they were discovered to provide little new information. For two of the remaining seven operations there was a wide range of responses from the critics. Specifically, there was little consensus regarding (a) the definition of therapeutic exigences and (b) the nature of responses encouraged. Therefore, although theoretically and conceptually these two operations may be important in explaining

a therapist's rhetorical activity, they still require further refinement and will not be reported on in this paper. Similarly, the question concerning "simplest interpretations" was necessarily omitted because of its direct relation to the issue of therapeutic exigences. Based on the independent analysis of six critics, then, what follows is a discussion of "therapist rhetorical potency," defined theoretically as "the capacity of therapist discourse to influence."

It appears that the concept in all probability is multidimensional in nature, dependent on the following four concepts:

1. Extent of ethos appeals
2. Extent of logical appeals
3. Extent of tension release mechanisms
4. Extent of stylistic devices

Each of these variables will now be discussed. First each concept will be operationalized, then specific segments of therapeutic dialogue will be presented to demonstrate how the concept functions as a rhetorical resource.

Extent of Ethos Appeals

Based on the earlier discussion of therapist credibility, this variable is operationalized by eight different behaviors that a therapist might perform. It is contended that if therapists behave in any of the following ways, their ethos is likely to be enhanced:

1. Therapists may directly refer to their own expertise in a given matter.
2. Therapists may indirectly demonstrate their expertise by labeling or naming what is wrong with the client, referring to related research findings and experience with similar cases.
3. Therapists may make recommendations and suggest possible solutions.
4. Therapists may communicate an interest and concern for the client's welfare as well as an optimistic outlook.

5. Therapists may assure clients of confidentiality.

6. Therapists may reveal values, opinions, experiences which they share with their clients.

7. Therapists may communicate understanding of a client.

8. Therapists may communicate high esteem for a client.

In the following segments of therapeutic discourse, the therapist's talk has the potential to heighten his ethos in a number of ways.

Session One

T: It sounds to me that your head is very well together in terms of the way you're looking at this . . . . You're not shitting on yourself and saying, "I'm responsible for what happened with ____." I like the way you're handling it by saying, "I'm going to take a breather from this relationship and I'm not going to make any commitments or plans for what I do within the next week or month. On the other hand your perception of yourself--speaking as professional to professional for a minute--is not a-typical. In the last 5 or 6 years I would say about 30 to 40 percent of the clients that I see present situations where . . . well if you run down the characteristics which in our culture theoretically should make you an ecstatic person, you're in the upper 10 percent of the distribution in almost everything: You're in good physical condition, you're obviously intelligent, physically attractive, you don't have any trouble attracting the opposite sex, you're successful in athletics, you've been successful in school, prestigious occupation. Yet, in spite of the fact that from someone else's perspective you seem to have everything going for you and you have no reason to feel badly about yourself or complain about your life situation, your perception of yourself is quite a bit different than that. Even though at a cognitive level, at a rational level, you can agree to all this; you can say, "Yes, I'm in good physical shape. I'm intelligent. I'm attractive. I'm good in athletics. I'm a talented professional" . . . even though you can give these relatively rational responses, at a gut level you still feel relatively insecure about yourself. Judging from some of the research in the clinical field there are some common themes running through this. One of perfection striving. One of the reasons you have been good as an athlete and in your profession is that you seek perfection. You don't just want to be better than the group, you want to give it everything you've got and be as good as is humanly possible. That obviously has advantages. If I'm undergoing surgery that's the kind of surgeon I'd want. The problems that arise are when those standards start to carry over to your evaluation of yourself.

* * * * * *

C: There's been a little change in the last few months . . . I may

not be changing enough, but I'm feeling a little bit of change.

T: Notice: "I may not be changing enough even though I'm changing." You're not only talking negatively about how you stand, but you're talking negatively about how you're moving. It's not only the product that's inadequate . . . . It's the transformation that's not at the right pace . . . . So that you will never be satisfied with the change because even though you're making changes in what seem to be a good direction, they're not large enough, they're not fast enough . . . . And I would predict . . . . without knowing . . . that people have probably told you that you get very frustrated over minutae.

C: I do.

T: Things have to work well . . . . If the car doesn't run right or something you get very upset about it . . . . And it's not the money aspect . . . it's things going right. You probably are well organized . . . . Some people have probably called you meticulous either about personal hygiene . . . about the way you store your clothes or something like this. And again all of that is a reflection of the kinds of standards you set which I think is something we can work on if you want to.

First, there is considerable talk about this therapists' professionalism, his knowledge, and his ability as a therapist. In lines 7-10, for example, the implicit message is: I have been doing therapy for a long time; I have had many clients; I can spot trends. Lines 25-27 point to his familiarity with the research of his field. In lines 43-53, by making some accurate predictions, the therapist provides a further opportunity to enhance his credibility as "one who knows." Thus, on several occasions, the therapist has provided an opportunity to heighten his ethos with talk that explicitly suggests he is a competent and experienced professional.

Another opportunity for credibility enhancement by this therapist is provided by talk which suggests his high esteem for the client. Lines 10-16, for example, indicate this positive regard. In addition, on several occasions the implicit message of the therapist's words is: "You're moving in a positive direction and that is something to be proud of:"

T: Well I think that . . . not only have you made a decision that I think is in the right direction, but I think you're already moving . . . . You're coming up with things yourself . . . some observations that I think are extremely valid not only in terms of where you've been, but where you are right now and where you're

65 going . . . . And I feel very good about where you're going to be.

* * * * * *

208 T: I like what I'm hearing . . . . Particularly this week it
209 sounds like you've made a lot of movement in your head; not in
210 terms of answers, but in terms of asking questions and feeling
211 more comfortable with being in a position to explore . . . And
212 I think that that's a sign of . . . partly in terms of independence
213 . . . and partly that you're willing now to look at some things
214 that in the past were taboo to even consider. That is, taking a
215 day off when you don't have something else to do . . . . So it
216 sounds like you're making some movement there . . . . It seems
217 like in terms of vocational, job kinds of things . . . it sounds
218 like job wise you feel fairly comfortable for the next half year to
219 a year to see of the last week is any indication that things are
220 going to be a lot more bearable in your work situation . . . and
221 then in a year from now or so depending on what it looks like with
222 Dr. X, how you've changed the situation, how your head is feeling
223 about not pushing so hard and taking some time off . . . then
224 maybe reconsidering that. So . . . it sounds like . . . what a
225 week or two ago when the job thing was really keep ng you up nights
226 and making you anxious . . . now that seems to be tidied up a bit,
227 marked "to be explored" and set aside.

* * * * * *

248 T: I can't believe the movement you've shown in the short period
249 of time already . . . . You're a therapist's dream in terms of a
250 client . . . in terms of being very much into what you're thinking
251 and where you're going . . . . Are you aware of how differently
252 you're coming across now than three or four weeks ago?

253 C: I feel differently.

254 T: I wish I had saved the tapes so that you could listen to your-
255 self or see yourself . . . . That's very different from the way
256 you were coming across then.

Although this talk is not directly aimed at heightening the therapist's professional image, it has the capacity to raise his ethos by communicating high esteem for the client as well as an optimistic outlook.

Therapist II's talk has the potential to heighten her ethos in a number of ways. Her most obvious and frequent means of raising ethos is to communicate her understanding of the client, often coupled with expressions of interest and concern for the client's welfare. One strategy for accomplishing this is to make inferences about what the client is thinking, by putting her presumed thoughts into dialogue form:

32 T: So you're angry at her?

33 C: Yeah.

34 T: Yeah. I think part of your line is, "You don't play fair, lady.
35 you don't play fair at all, and I wanta play fair." That's Natalie?

* * * * * *

353 T: Should I demand more and run the risk of losing what I've got
354 or am I saying, 'I am really not very worthy so I'll take what
355 I can get and not run any risks.'

356 C: That sounds pretty accurate.

* * * * * *

357 T: Yeah there is, that's the dingling voice that's saying you're
358 being made a fool of, you're being taken advantage of, you
359 don't have any self-respect, you don't have any pride, uh,
360 you don't think well of yourself or you wouldn't put up with
361 this. It's that voice.

* * * * * *

446 T: You're telling yourself over and over again, 'He went out with
447 Cathy. That was perfectly terrible. It means something awful.
448 It may mean the end of our relationship. He probably doesn't
449 love me.' You're doing a circular trip like this, which is
450 very tormenting to yourself, which is putting you down and
451 saying you're shit.

* * * * * *

462 T: So you're doing what I do. You're not missing any of them.
463 (Laughter). That's the last one I think which is, 'and maybe
464 I'm just kidding myself and maybe I ought to pound myself
465 over the head for that, too. I ought to be smart enough by
466 this time not to kid myself anymore. Yeah, yeah. Maybe
467 I'm just being a dumb, blind idiot.' Right?

The therapist also communicates her understanding of the client by labeling emotions she perceived the client to be experiencing. Since the client never expresses these emotions directly, the therapist's labeling them is likely to add to her image as one who has a definite understanding of the client's "inner self:"

134 T: Yeah. It sounds like that fits with your description of your
135 family that, that was your position that your sister's position

was the one that got attention by anger and conflict and excitement, so to speak. Emotional turmoil. And you got attention by being compromising, undemanding, independent.

C: Uhm.

T: And able to take care of yourself.

C: Yeah.

T: And somewhere along the line you decided if you tried to compete with your sister you were going to lose. You better find another strategy, right?

C: For sure. Oh for sure, that's true.

* * * * * *

T: Yes. That's the one phrase that would really, uh, she could call you a lot of things, but I suspect that 'uptight' and 'selfish' would be the two that would totally rack you up. You would sit there for hours worrying about whether this was the case.

* * * * * *

T: It seems like the thing you need permission for now is to be really pissed at Bob for being such a no toast about this whole thing.

C: Yeah. I can't.

T: Yeah. I'm in touch with the fact that that makes you very angry. Given how much you displace on Barbie.

* * * * * *

T: Yeah. What you want is a more committed relationship than you have; what you want is Bob telling you that he loves you and expressing that a lot, so that you're given a lot of reassurance. What you want is to not be panicked about the future and by being hurt. And you're behaving to get those needs met.

This therapist also communicates her understanding of the client by discovering, labeling, and interpreting patterns in the client's past and present behavior:

T: Most people repeat their patterns unless they become conscious of them . . . and choose to do differently, and your pattern apparently is to become independent and find something else rather than to make demands in the situation that you are in; is what I was looking at.

C: I think that's accurate.

T: And that seems to have happened twice in major cases in your life in terms of leaving your family and in terms of leaving this relationship in Arizona.

C: And maybe, yeah, there's, I lived with someone for almost 5 years, most of while I was going to Berkeley, and I do have a pattern of leaving. I know that. And of not staying and clearing it up. I did. I really want to change a lot and yet that . . .

* * * * * *

T: I have a suspicion that you're concerned with the manipulation as it comes from your own desire to do that planning against her. You do it in trying to control your feelings, for example. That it's not cool to come apart at the seams about Cathy, so you fight to control, which is in fact manipulating him because you're not being direct with him about what you are feeling. You're playing like 'I'm going to accept you being partially committed' when you don't want to.

C: Yeah, I don't want to.

T: So, uh, my sense is that ypu're probably doing a pretty fair amount of that, and then being pretty pissed at yourself for doing it. You know, balancing back and forth between trying to be nice to him in order to get him to love you and then saying, 'God damn it. I'm not getting what I want. This is terrible.' And that this comes out in being very concerned about the fact that other people can manipulate him. Being real angry at these other manipulators, and I guess that the manipulator that you're really angry at is you.

C: It's me.

T: Yeah.

C: Yeah. I guess so. I don't, I guess it's just much harder to see your own, I can't, maybe I manipulate backwards or I manipulate by not, in a passive way. I don't know, it's real hard for me to see what I'm doing.

In addition to communicating her understanding of her client, the segments of discourse cited above are also likely to heighten the therapist's ethos by suggesting strong interest and concern for the client's welfare. Examination of the client's discourse provides evidence that this message was, in fact, communicated:

. . . what I liked about seeing you was that I felt like you were my advocate, sometimes even when I wasn't, you know, about sort of washing out some of my feelings. And it made me aware of some things that I hadn't before.

Extent of Logical Appeals

Therapist claims will be said to contain logical appeals under any of the following conditions:

1. Supporting examples are presented. These examples are often drawn from past and present client behaviors, other relevant cases, other persons' behaviors.

2. Statistics are presented. Therapists may provide numerical evidence to support claims.

3. Citations from authority are presented. Therapists may quote relevant authorities or professional literature.

4. Analogy is presented. Therapists may support claims through comparisons. Analogies often compare present to past behavior, client behavior to other behavior.

Examining Therapist I's discourse in lines 6-33 on page 14, the claim appears to be:

> Your problems arise from perfection-striving, setting standards that are unrealistically high.

The likelihood of the client's accepting this claim is increased by the large amount of evidence offered to answer the client's possible question: "What have you got to go on?" In fact, most of the 27 lines of talk provides data encouraging acceptance of the major claim. The data consist of examples, statistics, and authority references. The following data are provided to indicate perfection-striving in the client's life:

> you're in the upper 10 percent of the distribution in almost everything (statistics)
>
> good physical condition
> obviously intelligent
> physically attractive
> don't have any trouble attracting the opposite sex
> successful in athletics
> successful in school
> prestigious occupation
> (examples)

YET . . . ON A GUT LEVEL YOU STILL FEEL RELATIVELY INSECURE

The warrant for accepting the therapist's general claim is implicit:

> If a person has so much going for him and still feels insecure, it is reasonable to believe his standards are too high.

To make the client's acceptance of this claim even more likely, the therapist offers statistics and authroity as further support. This type of data is especially appropriate with this client-as-audience because he is a member of the "scientific comuunity." The extensive use of numbers and percentages adds to the scientific sound of the therapist's evidence.

> In the last 5 or 6 years, 30 to 40 percent of the clients I see present similar problems.
> (statistics)
>
> Judging from some of the research in the clinical field, . . . there is a theme of perfection-striving running through this.
> (authority: research data)

The implication appears to be:

> According to scientific research, perfection-striving is a real problem . . . and the data don't lie.

To further clarify this process of logical appeals, let us examine a segment of discourse from Therapist II's third session in which the initial claim was rejected by the client. In lines 389-413 on page 19 the therapist's claim appears to be:

> Your concern about the manipulations of other people is really based on your perception of yourself as a manipulator . . . . The manipulator that you're really angry at is you.

The therapist provides no evidence, and the client rejects the claim at this point, saying, "I guess it's just much harder to see your own. I can't . . . I don't know, it's real hard for me to see what I'm doing." The therapist then shifts her strategy by redefining "manipulation." "I don't use that word

in a negative sense. Manipulation means for me getting or attempting to get what you want." With the addition of this qualifier, the therapeutic claim is now altered and becomes:

> Your behavior can be considered manipulation by qualifying the definition of manipulation to mean acting in ways to get your needs met.

The data presented in support of this qualified claim consist of specific examples of needs, goals, which the client has tacitly admitted she has:

> What you want is a more committed relationship than you have.
>
> What you want is Bob telling you that he loves you and expressing that a lot, so that you're given a lot reassurance.
>
> What you want is not to be panicked about the future and not being hurt.
>
> (examples)

The warrant which bridges the gap from data to claim is explicit:

> And you're behaving to get those needs met.

With the qualifier added and the warrant explicitly supplied, the client is able to accept the therapeutic argument. She says, "Yeah . . . that really rings true to me."

Extent of Tension Release Mechanisms

In examining this component of therapist rhetorical potency, we shall look first for problems vivified by either therapist or client and then for the availability of tension release mechanisms at those points. Tension release mechanisms consist of the following:

1. Discourse which describes the client's situation as being hopeful, solvable.
2. Discourse which reconceptualizes the client's problem in more manageable, less traumatic terms.

3. Discourse which suggests that change is already taking place, progress is being made.

4. Discourse which offers direct solutions.

Examining Therapist I's first session, it is clear that a problem is vivified by him. The implicit message from the therapist seems to be:

> You are feeling anxious and tense because you seek perfection; unless you modify your standards of self-judgment, you will continue to feel insecure. (See lines 6-34 on page 14.)

The question now becomes: If the client accepts these problem, is he offered a way out of the accompanying anxiety and tensions?

After spending considerable time vivifying the problem of a perfection-striving, the therapist concludes by offering his client a "solution" (lines 54-55 on page 15). It is:

> Your problem of perfection-striving standards is something you can overcome if you want to; although it is a problem, it is one we can work on and solve.

Further release from tension is offered in lines 67-89:

and I guess one of the reasons I enjoy talking to you . . . not only because I like you, but because I've had some experience that parallels yours, partly in terms of the perfectionism . . . about how I feel about myself . . . I've had to work on that . . . . I've had to work a lot about how I feel about me . . . what my standards are . . . I share the physical fitness thing . . . . And I guess one of the things that was most important in my feeling good about me was realizing . . . I was always waiting for the day when I would wake up and say: "I'm there. I've got my shit together." And the thing that was most missing from me was something that will come across a lot in my speculations with you and that is that you never arrive . . . you never get there . . . . And it's the realization that you never get there that's getting there. It's always a journey rather than a destination. You never hear the whistle and say, "This is the stop." Because you're always moving . . . always rolling with the punches. I think that part of the empty feeling that I had and some of what's coming across as part of the empty feeling that's missing is that you haven't gotten anyone either from the outside or the inside to say, "You're there. You've arrived." And I think it's going to have tremendous benefits to you when you realize that you're never going to get set . . . that you're never going to arrive . . . . And so it's not playing the game to win, it's playing the game to stay in.

In this segment the therapist discloses that he, too, had problems and anxieties similar to those of the client, and he has been able to resolve his difficulties. This has the potential to provide some release from tension. Further relief from anxiety is offered in lines 73-79. Here the therapist offers his client a new way of conceptualizing his problems and anxieties. If the client accepts the notion that "you never arrive because life is a journey and not a destination," he cannot feel as anxious about "not getting there." Thus, in the first therapy session a problem of perfection-seeking is vivified by the therapist, who then offers his client several avenues leading to tension release.

During Therapist III's second therapy session the client begins to develop what appear to be dysfunctional responses to therapist-created tension. On two separate occasions, when confronted with anxiety-heightening rhetoric, the client responds by defending himself in a vague, ambiguous manner. In lines 280-284, for example, the therapist creates tension but offers no release.

280 T: Then what's really bothering you? You want to be aware of
281 what you're interested in and you want to know it and you want to
282 do it and yet here it is all in front of you like a smorgasbord
283 and you go up to it and then back off. What is, what's bothering
284 you?

His message seems clear:

> It's all there in front of you and you just won't take it.
> What's wrong with you?

The client's trigger reaction is to revert to a behavior pattern that the therapist had been attempting to modify. That is, he does not deal directly with the therapist's probe, but counters in vague generalities:

285 C: (Clears throat) I wish I knew. I wish I knew. I wish I
286 could stop worrying about it and just do it. And, you know, just
287 get involved with and not being overwhelmed by what I am. Am I
288 doing a good job and everything? I just want to become absorbed
289 with a more positive attitude.

This pattern may be seen again in lines 302-309:

302 T: Yeah, made you feel the competition was greater, the demands
303 were more something in the way that made you look less confident,
304 more unsure of yourself than you had been. And so you go up to,
305 I guess, your work, and you start either doing it half-assedly or
306 backing off and procrastinating is the way I think you put it.

307 C: Uh hum.

308 T: And the question is, if you really want to get through how come
309 you do that?

In this segment of discourse the therapist's message seems to be:

> Why do you procrastinate and do a shoddy job when you say you want to get through?

Rather than confront the issue directly, the client again responds by defending his behavior and blaming his procrastination on being "overwhelmed:"

310 C: It's not like I'm uhm (clears throat), it isn't like I'm not
311 attacking the work. It's not like I'm taking all easy courses.
312 I'm taking as much and sometimes I think part of it is I become
313 overwhelmed with my work.

We can reason that these instances of nonreleasing rhetoric failed to fulfill the demands of this therapeutic situation. By generating tension and offering no way to alleviate it, the therapist encouraged responses that were representative of a client behavior in need of modification.

Extent of Stylistic Devices

In examining this component of therapist rhetorical potency we shall be looking for the extent of balances, antitheses, metaphors, sensory images and their capacity to intensify the content of therapist discourse. In Therapist II's second session she attempts to convince her client that her fear of being perceived as "uptight" is a function of her Berkeley peer group among whom "uptight" behavior is considered a severe violation of norms to be castigated. The therapist attempts to convince her client that human feelings are different from theoretical principles and that any feeling is legitimate -- includ-

ing feelings that might be labeled "uptight" by the Berkeley group. The client's response to this discourse indicates her acceptance of the therapeutic message: "I think I would. Yeah . . . I do . . . Ooh. I hadn't ever thought of it . . . . Right . . . . It's true . . . . Right. Yeah." An examination of the therapist's stylistic devices shows us that choice of language was a rhetorical resource available to the therapist. Following are the lines from which stylistic features below were compiled.

214 T: My guess is that it would be a heavy attack on you because of
215 what looks like a substitution of Berkeley for your family.
216 Is that,

217 C: Explain that.

218 T: In needing a family you used Berkeley as a family. And so it's
219 very important for you to live up to their principles, just as it
220 is to somebody who is still very attached to their family to live
221 up to their family principles.

222 C: Uh.

223 T: And one of those principles is not being uptight. Right?
224 (Laughter.) It's probably A #1 principle is 'We are liberal.
225 We are not uptight.' And to be accused of being "uptight" is
226 to be accused of being a traitor to your clan.

227 C: Ooh. I hadn't ever thought of it.

228 T: (Interrupting.) This is a basic accusation that is very, very
229 hard to handle when it hits at: that's the thing that makes me
230 a part of the group that is most important to me. Mine is a
231 group where people are not uptight, where they are liberal and
232 can stand nonnuclear families and can look at life in broader
233 terms and can be loving, and you know, all those things are
234 part of that, a, that folklore that makes your group a group.
235 So, when you are attacked on that, it's like attacking a Christian
236 on his belief in Christ. Right?

237 C: Right. In fact, we call it our mythology. (Client laughs.)

238 T: Yeah. Right.

239 C: And there's that kind of 'this is ridiculous but.' Yeah, it's
240 true.

241 T: And the difficulty is that human feelings are human feelings

242 whether you happen to believe in being liberated or in being a
243 Christian or whatever you happen to believe in. You know if
244 you are jealous, you are jealous, and if you're feeling re-
245 jected, you're feeling rejected.

246 C: Right. Yeah.

Balances

uptight and selfish
to be accused of . . . is to be accused of
when you are . . . it's like
human feelings are human feelings
happen to believe in . . . happen to believe in
they are . . . and can . . . and can . . . and can . . .
believe in being . . . in being
if you are jealous, you are jealous
if you're feeling rejected. you're feeling rejected

Antitheses

she could call . . . but I suspect
where people are not . . . where they are
We are . . . we are not
Whether you . . . or . . . or

Metaphors

totally rack you up
heavy attack
attached to their family
very hard to handle
look at life
attacking a Christian
traitor to your clan
it hits at . . . the thing that makes me a part
you are attacked

Sensory Images

call you a lot of things
uptight (repeated)
Berkeley (repeated)
family (repeated)
needing a family
accused of being uptight
feeling jealous
accused of being a traitor
a group where people are not uptight
nonnuclear families
be loving
being liberated
being a Christian
feeling rejected

The therapist's uses of balance, antithesis, metaphor, sensory images, have the capacity to intensify the content of her talk. Let us now consider more specifically how this is accomplished. The balanced constructions are likely to make the ideas appear more "sweepingly true," "impressive," "important" (Arnold, 1974, p. 168). They also have the capacity to make the thera-

pist seem more "logical" to her client. The content of the array of balanced constructions is striking; each balance contributes to the impact of one of three therapeutic messages:

1. You have substituted Berkeley for your family.
2. Being perceived as uptight is extremely difficult for you to handle because it goes against one of Berkeley's most important principles.
3. Human feelings are all legitimate--even if they are indications of being "uptight."

The therapist also employs antitheses to argue by emphasizing contrasts. By contrasting "We are liberal" with "We are not uptight" the therapist emphasizes the extremes of the Berkeley philosophy and the implicit impact these contrasting ideas have had on her client's values. The therapist also employs antithesis as she attempts to convince her client that any feeling is legitimate, even though it may be perceived as less than liberal on the Berkeley hierarchy of values. By focusing the client's attention on contrasting belief systems, ("Whether you happen to believe in being liberated or in being a Christian or whatever you happen to believe in . . . ."), the therapist is able to emphasize her residual message: Even in diverse belief systems, human feelings are human feelings--they are always legitimate. In short, by setting ideas against each other in antithetical constructions, the therapist increases the likelihood that she will influence her client.

The therapist's abundant metaphors, in addition to adding color and interest, also seem to function argumentatively. Most bring into figure a message of: "It is because you have substituted Berkeley for your family that you find it difficult to handle being perceived as uptight." Thus, the metaphors, like the balances and antitheses, focus on a prominent therapeutic message.

The possibility of the client becoming "experientially hence feelingly" involved in the therapist's talk is enhanced with the abundance of sensory images (Arnold, 1974, pp. 168-169). In addition, these sensory images appear to work together to alter the client's feelings toward "uptight" behavior. "Uptight" images are contrasted with "liberated" images thereby serving as an antithesis-generated argument. Once more a stylistic device focuses the client on Berkeley's hierarchy of values as the source of her distress. The therapist's sensory images also have the capacity to evoke and sustain feelings and impressions which are vital to the therapist's argument.

From this examination of style, then, it has been shown that the therapist's uses of balance, antithesis, metaphor, sensory images, represent rhetorical resources that have the capacity to intensify the content of her talk.

Limitations and Conclusions

The goal of this investigation was not to produce generalizations about therapeutic outcomes. Rather, this represented an attempt to apply a critical methodology to a process not previously regarded as amenable to that kind of examination. The purpose of the study was neither to look for obvious uniqueness among therapists nor to evaluate the rhetorical effectiveness of different therapeutic schools. The purpose was to search for and identify consistent uses of rhetorical strategies discernible in distinctly different forms of therapy. Our primary concern was to develop and test a methodology and to uncover hypotheses. The general purpose of the study was to discover whether rhetorical criticism could be fruitfully applied to psychotherapeutic transactions of differing kinds. The therapists whose work was examined do not constitute a representative "sample" of therapeutic dyads. Nor is it being argued that the therapists were randomly selected and were in that sense "representative." The purpose here was to discover whether rhetorical activities transcend particular approaches to therapy.

Although this kind of investigation prohibits broad generalizations, it is a test of a potentially useful way of describing the behavior of therapists engaged in modifying the behavior, thoughts, feelings of clients. Herein lies the study's utility; it is a first attempt to examine the talk of therapists as rhetoric in process. Despite the small number of therapists analyzed, this study constitutes an initial step toward verification of the hypothesis that rhetorical criticism is useful in the study of therapeutic change. With it demonstrated that rhetorical activity is fundamental to therapeutic practice, we are now in a position to begin exploring the relationships of various rhetorical strategies—or lack of them--to outcomes.

This study, then, has important implications for training therapists. It appears that training procedures which teach only the specific content of one therapeutic approach are severely limited. Considerable emphasis should be placed on the structure and strategy by which a therapeutic message is delivered. Regardless of method, it appears that students of therapy would profit from an understanding of the rhetorical resources available to them. We may now be able to teach neophyte therapists a method for discovering the nature of their therapeutic situation in any given case, and what their rhetorical resources are within that situation. The opportunity is present, then, for the therapist to ask questions before the fact much as the critic does after the fact. We already do this in public-speaking situations; there is no reason to believe it cannot be done in private therapeutic transactions.

That such a step has utility is strongly implied by Mahoney.

> We have devoted invaluable human skills and material resources in efforts to change beliefs about the relative merits of deodorants and political candidates. Meanwhile, our clinics, hospitals, and homes are inhabited by individuals whose existence and daily well-being are painfully jeopardized by dysfunctional beliefs . . . .

> Had we devoted as much time and concerted research effort toward refining the techniques of therapeutic belief change as we have invested in marketing reserach, the pervasiveness of contemporary thought disorders might have been dramatically reduced. Needless to say, our priorities are in need of re-examination (Mahoney, 1974, p. 238).

If psychotherapy is a rhetorical process, examining its rhetorical components may reveal why and how it succeeds and fails, thereby allowing therapists to maximize the occurence and maintenance of therapeutic improvement, and allowing rhetoricians to better understand the processes by which individuals are persuaded by other individuals. Therapists would gain access to a body of rhetorical literature with potential for improving therapeutic effectiveness. Rhetorical scholars, by studying the theory and procedures of psychotherapy, could receive insight into the process by which behavior, thoughts, feelings are changed or modified through talk.

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